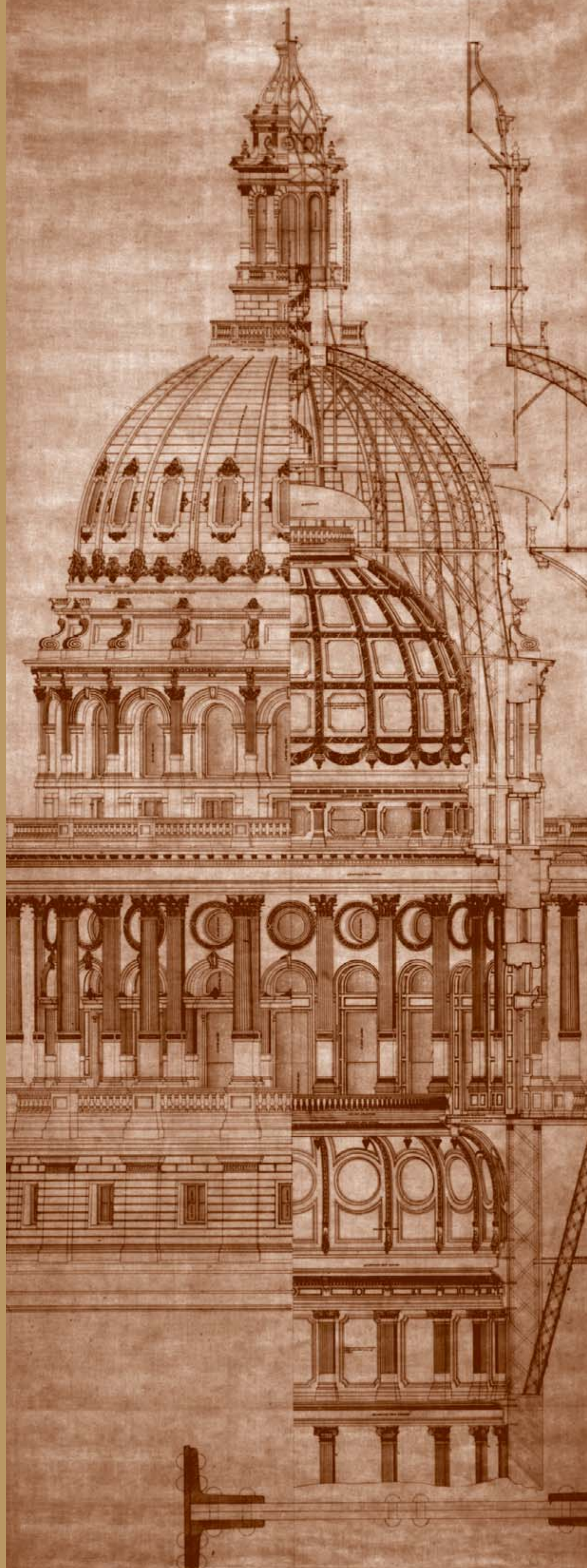
Community Leaders' Blueprint for American Health Care Policy

January 2005

Administered by:

Foundation for American Healthcare Leadership℠

An affiliate of Wye River Group on Healthcare



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Community Leaders' Blueprint for American Health Care Policy & National Study on Consumer Health Values

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Community Leaders' Blueprint for American Health Care Policy

84 Health Care Public Policy Recommendations

January, 2005

OVERVIEW

The Foundation for American Healthcare Leadershipsm (FAHCL) has created a "blueprint" for health reform that can be used by the Bush administration and the 109th Congress as a roadmap for addressing key challenges in health care policy. We thank the nearly 150 individuals who contributed their ideas, through our community leadership advisory panels; completion of a detailed health policy survey; and participation in the blueprint development process described below.

The blueprint was principally developed through a methodical combination of electronic brainstorming and facilitated discussions, and involved direct input from community leaders across the spectrum of health and health care, as well as many prominent national thought leaders in health care policy. Many diverse communities were represented, including the 12 involved in Wye River Group on Healthcare's "Communities Shaping a Vision for American's 21st Century Health & Healthcare" initiative. These communities include Albuquerque, NM; Chicago, IL; Fort Lauderdale, FL; Northern NH and VT; Muncie, IN; Jackson, MS; Portland, OR; Raleigh-Durham, NC; Salt Lake City, UT; San Diego, CA; San Antonio, TX, and Spokane, WA.

The blueprint's practical recommendations frame a series of actionable steps that can reasonably be advanced within the next administration's 4-year term. Prior to beginning development, the idea was vetted with policymakers in both the Bush administration and the Kerry campaign, and the process enjoyed their support.

The process captured 340 ideas and recommendations on a wide range of health care public policy issues: access, incentives, affordability, public health, incentives, public awareness, and several more. Using the Washington session participants to vote and prioritize, we collapsed the 340 ideas into 84 distinct recommendations, set out below.

This is a unique document that directly captures scores of community leaders' ideas for healthcare policy, and the role of government in enabling communities to meet the needs of their residents. We asked the participants to take this opportunity to express their views on government more broadly. There was agreement that an appropriately defined role for government is a critical component of a well-functioning healthcare system, but few of the participants advocated for a centralized single-payer approach.

As the largest single purchaser of health care services, government has a huge stake in how well the health care system functions, and should leverage its role to promote quality, efficiency and appropriate resource allocation. It should reward the practice of evidence based medicine, advance quality metrics and fund demonstration projects that pilot new ideas and models designed to improve the overall health of our nation.

As a public policy maker, government should carefully balance social interests. Community leaders emphasized that flexibility should be a hallmark of effective government. They suggested that existing regulations be periodically examined to identify barriers to innovation.

Government may also have a third role to play as an effective communicator, making a healthy America synonymous with strong America.

Under each section of this report, we have provided the question posed and brief comments that relate to the overall perspective of community leaders, especially as they reinforce the values and principles for health policy elicited in community discussions. We then list the ideas and recommendations for which there is the "making of a consensus" between community leaders and Washington-based organizations on specific actions that can and should be undertaken to advance health and healthcare improvements. The recommendations all had a mean of 6.5 or higher on a scale of 1 to 10. This information has been generally sorted into those recommendations that reflect a call for re-evaluation of public policy and those ideas specifying an implementation recommendation.

RECOMMENDATIONS

Public Awareness

Question: Many people believe that a critical step in addressing our health care challenges is increasing the awareness of the public about those challenges and gaining broad agreement on a vision for our healthcare system. Are there actions the President (Administration) could/should take to facilitate public dialogue on health and healthcare and to engage citizens?

General comments: Most of the leaders felt that the public does not realistically understand the current dynamics relating to limited resources, the need for tradeoffs, and the importance of an increased role for individuals in better managing their health. To sufficiently get the public engaged, we will need to create a clear goal, akin to "a man on the moon," and develop a methodical, aggressive campaign to make healthy lifestyle decisions "cool." We need a theme, e.g., *"Health is every BODY'S business."* Or *"Nobody cares about your health as much as you do. Take charge!"*

There was broad agreement that going "upstream", reaching the younger generation with messages and tools for prevention will have the most lasting impact. Engaging schools, churches, social and civic clubs to promote and integrate more information about health and health care will affect kids and parents at same time.

It was also suggested that we need to create a national blueprint that is supported and endorsed by a wide range of stakeholders and a set of national messages that could be part of an overall ad /PR campaign, in other words, a shared vision. Get the word out using a broad array of media, including Internet, radio, and TV. Engage community, business, and social leaders to be part of high visibility efforts in their communities.

Public policy recommendations:

1. The President and Secretary, HHS should articulate specific, measurable healthcare reform goals with timeframes and develop a national report card which shows progress against the national goals--(e.g., percent of uninsured, prevalence of obesity, prevalence of non-compliance, and percent with adequately treated hypertension, mammography as recommended by national guidelines, etc.)
2. The President should encourage Congress to take up meaningful healthcare reform within a specific period.

Implementation recommendations:

3. The President must provide leadership by articulating a clear vision and statement of principles to move public opinion.
4. The President should hold a Summit with business CEOs and labor leaders to invite their participation in crafting solutions to healthcare challenges.
5. The President should promote key health messages in presidential and cabinet level speeches.

Personal Responsibility

Question: What actions could/should be taken by the President (Administration) to help motivate individuals to assume a greater sense of individual responsibility for their health and health-related decisions?

General comments: There is consistent support among the leaders for more individual responsibility, and general agreement that we need to evolve toward a system where consumers have more choice and control. However, it is recognized that we must take into account disparities resulting from race, ethnicity, income, education, age and health status, and not "blame" individuals for their health conditions. Personal responsibility also must be balanced with more institutional accountability.

Some took a "no nonsense approach," stating emphatically that individuals who practice good health habits should directly benefit in lower premiums (see Harris Interactive survey results). Others felt it that the prevalence of poor health habits is a societal problem, and as such, all should share the burden, with the "haves" providing significantly for the "have nots".

There was widespread agreement that we need to emphasize education on healthy lifestyles and wellness, starting with our youth in school. Numerous financial incentives from cigarette, alcohol and fast food taxes, to tax credits and coverage incentives were felt to have potential utility. Transparency of information on price and quality is another "tool" broadly advocated to support good decision-making. Some pointed out that money is a better motivator for episodic users of health care; information is more effective for those with chronic disease. "Shared decision-making" was widely viewed as holding promise for effectively engaging patients in a healthy open exchange that considers treatment options in the context of individual values.

It was wisely suggested that we look outside the health care field to determine what works to motivate behavioral change, for example, by considering the success of Sesame Street in educating kids, or how Proctor and Gamble makes soap detergent inspiring. All of these tools and approaches will be needed if we hope to begin to change generations of entrenched behaviors and sustain momentum moving forward.

Public policy recommendations:

1. Create incentives in the Medicare and Medicaid programs to improve access to prevention and early detection services.
2. Strengthen advertising laws to avoid encouraging unhealthy lifestyles. Make product labeling more prominent.
3. Develop a curriculum that integrates teaching personal health responsibility at all ages and in all subjects (e.g. use of nutritional labels in math).
4. Enhance personal responsibility for health insurance by creating incentives for individuals to buy coverage.

Implementation recommendations:

5. Ensure that federally insured patients have access to the information they need to make informed choices by introducing the concepts of measurement and transparency of cost and quality information

6. The administration should encourage health plans to give patients an annual report card with accepted measures and results for personal comparison.
7. Congress should give employers and health plans that adopt consumer governed health care models more flexibility to financially reward employees/members who make healthy choices.

Incentives

Question 1: There is broad agreement that incentives for health care providers are frequently misaligned. What actions should be taken by the President (Administration) to align incentives for the delivery system to optimize patient outcomes?

General comments: One of the fundamental flaws in health care emphasized by participants relates to the marked misalignment of incentives for all the major players in the health care system—from providers to payers to patients. As a result, our resources are largely spent on treatment of illness, not on keeping people well. An example frequently cited is the amount of resources spent for futile care at the end of life, a practice that distinguishes us from other developed nations.

There was virtually unanimous support for restoring balance in how health care resources are allocated, and better aligning incentives to support "better health over treatment". However, some were especially concerned about the increasing prevalence of chronic disease and wanted more emphasis on disease management as "tertiary" prevention and disability avoidance. This group worried about moving precipitously in the direction of more resources for primary prevention.

On the provider side, emphasis was placed on rewarding evidence-based care and outcomes, not on services. The underlying concept was reflected by one of our participants, who said, *"We should adopt a model that encourages varying payment for good performance. It is very appropriate in all other industries why not health care?"* Developing models where providers, payers, and patients can share in the savings from prevention, early detection and better care management was seen as a positive step in aligning incentives.

Public policy recommendations:

1. CMS should provide consistent reimbursement for prevention services in all federal programs, according to the US Preventive Services Taskforce guidelines.
2. Create a level playing field for payers to care for high-risk patients through full implementation of risk adjustment.
3. Establish a "no fault" system to encourage medical error reporting.
4. Make the collection and dissemination of patient outcomes data a prerequisite for participation in government reimbursement.
5. Allow states to deploy incentive arrangements to pay for promoting health in Medicaid programs.
6. Government should publicly disclose provider performance against quality metrics.

7. Make it possible for payers and others to use the CMS database in "real time" to provide on going feedback to providers in order to improve patient safety and assess guideline adherence.
8. Medicare should allow providers in multi-specialty groups to decide how to structure care of chronically ill patients to achieve more efficiency and decide how reimbursement should be distributed.

Implementation recommendations:

9. Extend the pay per performance demonstration project currently under CMS beyond hospitals and health systems to primary care providers.
10. Perfect outcomes-based contracting by incorporating the concept of value into performance-based payment equations.
11. AHRQ should support research on pay for quality performance measures to determine what works.
12. AHRQ should define a set of quality performance metrics for hospitals and providers and build them into Medicare and Medicaid reimbursement schemes.

Question 2: What actions could/should be taken to create incentives to provide benefits for which there is no short term pay off (e.g., preventive services, chronic care management.)

Public policy recommendations:

1. The President should require all health related federal agencies to develop plans for adopting cost-effective prevention and chronic illness care services for those whom those agencies serve.
2. Create uniform preventive services benefits under Medicare and align them with the US Preventive Services recommendations
3. The government should develop a methodology whereby it shares savings with plans and providers generated by interventions that meet qualified targets, with bonuses for demonstrating cumulative cost savings through early intervention.

Implementation recommendations:

4. Simplify and standardize oversight requirements for healthcare networks if they agree to establish common intake and assessment procedures, continuity of care policies, and single medical records for care planning across the continuum.
5. OMB and CBO should score the savings to the healthcare system from providing preventive services.
6. Congress should mandate a reanalysis of reimbursement for services provided to complex patients with chronic disease under Medicare and Medicaid with a focus on improving functional status and care at the end of life.
7. Provide funding to help communities develop, coordinate, promote, and sustain community-based programs - including patient navigator programs - that help patients obtain timely and appropriate access to the health care system.
8. The President should order a comprehensive review to assess the value of adoption of cost-effective prevention and chronic illness care services in all federally financed health care programs.
9. HHS should commission IOM to do a comprehensive analysis that examines the link between prevention and its resulting benefits (ROI), looking at wellness, productivity and economics.

Access

Question: Currently our country has many citizens who lack access to healthcare services either because they cannot afford insurance, are underinsured or face social, physical, logistical or cultural barriers. What actions could/should be taken by the administration to address this problem?

General comments: We learned through the community discussions that access to health care, through public or private means, is broadly seen as both socially desirable and economically beneficial. But access is about more than insurance coverage. The problem of access encompasses cultural and logistical elements as well.

Participants emphasized the need for a strong and sustainable safety net to provide for the medically disenfranchised. They also highlighted the importance of equitable health care that addresses health disparities. There was considerable support for the concept of a "medical home."

Ensuring access to health care coverage for all citizens was cited as a top priority for the Administration. As one leader put it, *"The government's role is to make access to coverage fair; the role of markets is to make coverage efficient."* Many felt we should define a "baseline" level of health care coverage and ensure a quality product is available to all, using subsidies as necessary. However, participants recognized the challenge inherent in the definition of "basic." Others favored an approach that placed the emphasis on access to a "baseline" of quality services irrespective of coverage standards or definitions.

Looking at the issue of access from a process perspective, participants demanded greater flexibility in regulations, in the tax code, and with grants and waivers. They want the freedom to craft solutions that meet the unique needs of their community.

Public policy recommendations:

1. Expand state-of-the-art cancer care to rural and other underserved areas by further exploring the use of telemedicine.
2. The government should provide financial incentives to recruit providers to areas of need.
3. Provide funding for state and local governments to offer basic preventive and catastrophic health care options for uninsured based on sliding fee scale.
4. Provide small employers with tax incentives to offer health insurance to employees.
5. The appropriate federal agency should identify and map the most medically underserved geographic areas and conduct demonstration projects to improve access to care in these communities.
6. Congress should ensure a stable source of funding for government programs
7. Empower states to enroll Medicaid and SCHIP beneficiaries in employer sponsored health plans. The federal government could pay the employee share of premium.
8. The President should encourage Congress to develop a long-term strategy to achieve universal coverage and to establish a schedule to reach this goal.
9. The appropriate federal agency should study the feasibility of creating a universal market-based health insurance model with an individual mandate, subsidies based on income, age, and disability status, and coordination similar to FEHBP

10. Help fund education for minorities and those willing to practice in rural areas and publicize this availability of funds.

Implementation recommendations:

11. Expand funding for federally qualified community health centers.
12. Assure permanent federal funding for state high-risk pools, covering up to 50% of annual operating costs.
13. Expand SCHIP eligibility to cover all individuals below poverty.
14. The government should allow individuals and employers to buy into FEHBP.

Affordability

Question: In community discussions the escalating cost of health care services is always a top priority. What actions could/should be taken by the administration to address the problem?

General comments: The issue of financing is at the heart of our nation's health care challenges, and affordability was seen as a keystone to greater access and a healthier population. Leaders recognize that numerous factors are contributing to the escalation of health care costs--expensive technology and pharmaceuticals; demographics; waste and inefficiency; malpractice; and 3rd party reimbursement.

Recommendations for coping with the cost crisis frequently focus on a segment of the cost pie, for example, pharmaceuticals or technology, yet, participants recognize that overall system inefficiencies, including waste and duplication of effort, need to be addressed. Greater transparency of information and accountability for all stakeholders were frequently cited as necessary steps. Other ideas relating to affordability are found throughout this document under quality, incentives, and access.

While opinions varied on what clearly adds "value" in health care today, concerns about appropriate technology assessment prior to introduction into practice were raised by many. Participants were in agreement that we need to have better measures to help determine value for all medical interventions.

Public policy recommendations:

1. Ensure government reimbursement rates cover the cost of care to avoid cost-shifting.
2. Direct the secretary of HHS to begin the process of negotiating large drug discounts for seniors under Medicare through bulk purchasing.

Implementation recommendations:

3. Medicare reimbursement should take into account evidence gained from clinical comparisons on the effectiveness of treatment.
4. Allow states to expand Medicaid drug discounts to other groups.
5. Support the enactment of Medicaid Nursing Incentive Act to increase access to Advanced Practice RNs.
6. Government programs should ensure the availability of effective and affordable medications through the use of generics and tiered co-pays.
7. Fund demonstration project to establish and test systems to allow safe importation of prescription drugs.

Quality/Safety

Question: What actions could/should be taken by the administration to promote widespread adoption of standards of care and quality improvement?

General comments: *"We need to differentiate between what's done for patients and how it's done"* said one leader. Participants clearly recognize the importance of consistent quality and standards of care to the overall improvement in health outcomes. The problem will be in gaining consensus with regard to specific standards, which currently differ from community to community. Who should decide--payers, purchasers or providers? Another concern relates to the application of a standard of care to a patient with multiple co-morbidities, where "customization" of care frequently results in better outcomes. Some feel it is important to also have communities weigh in on standards, to add an element of consumer satisfaction .

Public policy recommendations:

1. The Government should leverage its role as the largest single payer to promote quality, efficiency, and appropriate resource allocation
2. Congress should provide funding for development, publication and on-going evaluation of standards of care based on rigorous review of the evidence, relying on expertise and research to ensure the scientific strength of recommendations.
3. The Government should provide consumers with performance data on providers.
4. Health care standards and delivery of quality must encompass the health disparities in quality of care noted between various ethnic groups and this data should be monitored and incorporated into best practice guidelines.
5. Develop consumer report cards on complex care.
6. CMS should build performance requirements (with teeth) into contracts with providers.
7. The administration should encourage JCAHO and others to emphasize performance measurement/quality over process.
8. The administration should set goals for Medicare administrators to improve performance of Medicare in controlling the five top chronic diseases and then give administrators the flexibility to achieve these goals.
9. Require providers in government programs to use a common standard for patient records and other administrative tasks not yet covered by HIPAA.
10. Standards of care should be developed with "community," not just professional, input to add the element of consumer satisfaction.
11. The President and his staff should take a leadership role in building on the work of IOM and HHS.

Implementation recommendations:

12. Quality assurance standards should ensure that screening, diagnostic tests, treatment, rehabilitative and palliative care services and therapies are safe, cost-effective, and reflect the best science available.
13. As a condition to participation in government-funded programs, providers should be required to collect and publicly report healthcare quality performance data, such as those national measurement standards identified by NQF.

14. Require CMS to develop "system performance standards" for people with multiple, complex chronic conditions, that take into account the cumulative effects of care as a person's condition evolves over time and across care settings.
15. The administration should expand the 'NASA' model currently used in the VA healthcare system to identify, analyze and improve healthcare practices.
16. Develop a clearinghouse to review and serve as a resource for clinically proven guidelines and best practices.

Coordination of Care

Question: The aging of the population clearly means that more individuals will suffer from multiple complex chronic diseases placing a premium on coordination of care. What actions could/should be taken to address the current fragmentation in healthcare to promote continuity and coordination of care?

General comments: In community discussions across the country, leaders emphasized the increasing importance of better integration and coordination of services, with a greater focus on prevention and primary care, public health, behavioral health, and care management for chronic illness. In these discussions, the valuable role that could be played by allied health professionals, such as advanced practice nurses, pharmacists, etc. and the importance of integrating social services in a coordinated care model, was frequently mentioned. Similarly, the importance of ensuring access to a continuum of care, that includes mental and behavioral health, and oral health care services, was also pointed out.

Public policy recommendations:

1. Streamline Medicare and Medicaid regulations to eliminate conflicts in reporting, record keeping, care planning, admissions, and discharge planning.
2. IOM should research newer models of care delivery and financing that better integrate a continuum of services for patients with chronic disease.
3. Use current legislative authority to adopt care coordination techniques in Medicare.
4. Coordinate the disparate federal and state efforts related to serving people with chronic conditions at the local, state and federal levels.
5. Government programs should promote the integration of behavioral health and oral health services into the continuum of care to improve outcomes.
6. CMS should develop and implement new payment methods that reimburse the function of care coordination within Medicare.
7. CMS should establish care coordination for complex chronically ill patients as a separate reimbursable service under Medicare and Medicaid.
8. Congress should create a new benefit that gives every Medicare beneficiary with multiple chronic conditions a "primary provider" who is paid to coordinate their care.
9. Create incentives to increase the number of geriatric nurse practitioners.
10. Create new loan forgiveness programs to recruit and retain the necessary spectrum of caregivers for an aging population.
11. Create incentives for health systems to offer patients with multiple chronic diseases "health coaches" with expertise in co-morbid conditions.

12. Revisit Stark legislation to protect consumer from inappropriate and unfair competition while enhancing the ability of related providers to work together in achieving cumulative cost outcomes.

Implementation recommendations:

13. CMS should eliminate duplication and conflicts between Medicare and Medicaid regulations in serving dually eligible individuals.
14. Certify "care networks" which can demonstrate better continuity, coordination and communication through use of common medical record, team planning, etc.
15. Fund the Nurse Reinvestment Act in order to meet the growing needs of elders.
16. Support demonstration projects that evaluate the benefits of integrated mental health and primary care.
17. Create a complexity adjuster for clinics and physicians who serve a disproportionate share of patients with multiple, complex care needs, and simplify record keeping requirements.
18. Fund more PACE-like demos.
19. Simplify and standardize oversight requirements for health networks that agree to establish common intake and assessment procedures, continuity of care policies, and unified medical records for care planning across a continuum.
20. Adopt the Mental Health Commission recommendations to coordinate various funding streams for mental health services at both the state and federal level.
21. CMS should create a bonus incentive for health systems that sponsor specialty chronic care clinics which achieve specified quality and cost targets.
22. Establish a continuity of care requirement for providers who serve the same person.

Information Technology

Question: Information technology holds much promise for improving quality and safety, creating administrative efficiencies and enhancing decision-making for providers and patients. It is also the focus of much regulatory and legislative interest. What actions could/should be taken to advance the utilization of information technology?

General comments: The spirit of the community perspective on Information Technology (IT) is captured by the statement *"we need to avoid letting the perfect be the enemy of the good"*, by getting some initial successes in deploying usable information. While privacy was a concern for some, most saw vast opportunities to employ IT to help convert our "non system" into a system. Promoting and advancing IT is seen as a prerequisite to addressing many challenges we face in health care.

But there were cautions. IT is not a solution—it is a tool. The ultimately utility of information technology will be largely determined by individual behavior. Community leaders see the greatest impact of IT in its application to electronic medical records, elimination of medical errors, inter-linking of rural areas, and reduction of administrative costs. Other potential benefits cited include better collaborative care coordination, better access to healthcare information for consumers to facilitate decision making, and broadening of rural medical services.

Leaders cited standardization, incentives for investment and adoption, funding of pilots and demonstration projects, cultural adaptation by professionals and their institutions, and training of health professionals as critical steps in advancing the use of IT.

Public policy recommendations:

1. The appropriate federal agency should develop and require adoption of uniform standards for information to be shared and stored electronically.
2. The President should advocate nationwide adoption of health IT based on interoperability standards that support the exchange of clinical and administrative information among providers, payers, consumers and government.
3. The appropriate federal agency should work to build a broad-based consensus on defining the content and protections for a nationally uniform electronic medical record (EMR.)
4. The President should encourage and guide the adoption of standardized language and interoperability of health systems.
5. The administration should require all entities that are doing business with the government and have personally identifiable health information in electronic form to make that information available to patients as part of a national network for exchanging health records.

Implementation recommendations:

6. Link reimbursement under federal payment systems for capital investments in patient-related technology with a demonstration of improved patient outcomes in relation to the costs.
7. The appropriate federal agency should increase funds for and accelerate the MMA provisions for E-prescribing regional pilots.
8. The appropriate federal agency should increase funding to interconnectivity and inter-operability demonstration projects.
9. The appropriate federal agency should provide more grants for implementation of telemedicine to rural areas.
10. The appropriate federal agency should establish a public/private partnership to develop information technology that supports the continuum of providers needed to meet the ongoing care needs of people with serious and disabling chronic conditions.
11. The appropriate federal agency should make the necessary federal investment to facilitate transition to EMR, e.g., through tax credits, federal matching, etc.
12. The appropriate federal agency should offer incentives for funded entities to capture program utilization and outcomes in a web-based MIS system that has the ability to upload de-identified (but trackable) information between public health entities.

Innovation

Question: What actions could/should be taken by the administration to advance science-based medicine and accelerate adoption of strategies, /technologies, and procedures proven to lower costs or enhance quality?

General Comments: Despite the strong cultural support in this country for medical innovation, there is broad recognition that we do not have a clearly defined value proposition for many new technologies and treatments, prior to use in care delivery. Similarly, variations in clinical practice drive unnecessary costs on one end of the spectrum. On the other hand, many patients do not receive well-proven interventions.

As a means of advancing some of the recommendations related to innovation and value, many individuals have advocated consideration of the re-creation of an entity similar to the former Office of Technology Assessment, (OTA), or one loosely modeled on the National Institute for Clinical Effectiveness (NICE) in the UK. Some also recommend that we re-examine the early work of the Patient Outcome Research Teams (PORTS) with an eye toward the value of that approach in today's environment.

Public policy recommendations:

1. The administration should require periodic examination of existing regulations to identify barriers to innovation
2. The administration should consider a systematic process for moving prototypes into practice and ensuring on-going review of their utility and relevance.
3. The president should encourage cross agency collaboration and cooperation within HHS to accelerate the movement of new technologies and treatments from the bench to the bedside.
4. Identify and articulate 2 or 3 national priorities related to reducing chronic disease and disability, e.g. Alzheimers, diabetes, depression, and create tax subsidies and awards for demonstrating significant advancements in reducing the societal burden of these chronic illnesses.
5. The administration should facilitate the widespread adoption of and use of existing clinical protocols in Medicare and Medicaid.
6. The administration should, through an easily accessible government bulletin board, provide access to the results of government funded research.
9. The President should emphasize more research on care delivery “system” improvements.
10. The administration should support a collaborative effort between the government and private payers to develop standards of clinical trial design and reporting through a level playing field.

Implementation recommendations:

7. Congress should fund research on comparisons of new and existing treatment protocols, especially pharmaceuticals and medical technologies, to determine the most effective applications for the delivery of care.
8. The administration should selectively identify and test new models for sharing revenue generated from intellectual property produced by government sponsored research.
11. The President should consider streamlining the waiver process for states interested in integrating Medicare and Medicaid financing.
12. Medicare officials should systematical evaluate new technology and prioritize ways to lower the cost of care or improve quality using studies on comparable cost-effectiveness of competing medical interventions performed by AHRQ.
13. The president should encourage adoption of evidence-based clinical guidelines in federal programs, educate providers, and enforce guidelines by tracking down outlier performers.
14. The administration should consider federal investment to enhance and expand bioinformatics, nanotechnology, etc. which will help translate research more rapidly into practice, as outlined in the NIH director's Road Map Initiative.

Public Health

Question: There is broad agreement that we do not have a robust public health infrastructure in this country. What actions could/should be taken by the President to begin to build an appropriate public health system?

General comments: Public health needs to move up on the national agenda! It is inadequately funded, has little presence in medical education, and suffers from a lack of public support and visibility, not to mention a shared operational vision. Many leaders see it as an untapped asset, one for which there is enormous opportunity but whose potential is unrealized. To begin to move forward constructively, it is recommended that the IOM standards on public health be adopted as national policy and that state and local governments be given support and incentives to meet those standards.

Public health activities vary considerably from state to state and at times from community to community. There was strong agreement that there needs to be a better definition of the appropriate role of public health in today's society, with a consistency of activities. It is recommended by community leaders that the public health system be streamlined, consolidated, and coordinated at the state, federal, and local levels.

There is a strong sense that public health needs to assume a greater role in public awareness and education, and coordination, particularly in the areas of health promotion and wellness. The opportunity for public health to provide leadership in school-based health initiatives and in building public/private community partnerships are important examples.

Public health should serve as coordinator of population data collection and interpretation. It needs to develop the infrastructure necessary to assure better use of data in the coordination of care for community and population health.

Public policy recommendations:

1. The administration should raise awareness and make public health a higher priority by adopting a national policy to promote improvements in public health that address both physical and mental health.
2. The President should encourage the development of reporting systems and data analysis to provide early warnings signals when public health threats first begin to surface.
3. CDC should develop a 5 year plan with budget to ensure the vaccine development and production capability of the nation.
4. The public health system should be streamlined, coordinated, and consolidated at the state, federal, and local levels
5. The President should establish and present to Congress targeted goals for reducing healthcare costs based on reduction in prevalence and severity of disease and disability.
6. The administration should work with Congress to promote research on public health issues and facilitate data sharing with state and local governments.
7. The President/HHS Secretary should strengthen the Public Health Service and work toward further integration with the health care delivery system, especially primary care.

Implementation recommendations:

8. Congress should fund monitoring/surveillance systems for bioterrorism and emergency preparedness, which would also warn of outbreaks of disease.
9. Congress should increase funding to HRSA programs that provide financial support for students enrolled in public health degree programs through mechanisms such as training grants, loan repayments, and service obligation grants.
10. Congress should establish an incentive based federal/state funded system to sustain a public health infrastructure adequate to assure the availability of essential public health services in every community.
11. Using the model developed by the American Cancer Society (ACS) and its "One Voice Against Cancer," develop a similar program promoting public health.

Administrative Simplification

Question: What actions could/should be taken by the administration to relieve providers of unnecessary administrative and regulatory burdens in order to maximize the percent of healthcare dollars that support direct provision of patient care?

General comments: Clearly there is a relationship between creation of a robust IT infrastructure and the elimination of paper and instantaneous movement of important information for decision-making. Streamlining Medicare and Medicaid regulations, standardization of forms, codes, billing, and electronic medical records were the ideas most strongly supported by community leaders. However, some felt strongly that use of IT and the Internet should NOT be mandated.

Public policy recommendations:

1. The President should direct the Secretary, HHS to immediately streamline and simplify record keeping requirements, eliminating unnecessary rules and regulations that are identified as impediments to providers ability to offer the right care, at the right time, in the right place, at the right costs.
2. The administration should carefully review all healthcare regulations impacting providers with an eye to simplify and remove duplication, e.g. Medicaid restraint and seclusion regulations.

Implementation recommendations:

3. Seek legislation to integrate the administration of services for persons dually eligible for Medicare and Medicaid under a single authority to decrease complexities and limit administrative costs.
4. The Administration should launch a medical benefits card initiative, in parallel with efforts to create electronic medical records, to allow health plan members to easily transmit eligibility information to each provider and hospital, and to permit instant claims processing upon authorization by the insurer.
5. Congress should create a "sunset commission" to review all Medicare rules and regulations relative to on-going relevance.
6. Continue the investment in E-health and provide federal grants and resources to further promote and assist providers in use of HIT.
7. Medicare FFS should also adopt an instantaneous, card based electronic claims paying system.

8. The Administration should move toward the adoption of a medical benefits card through the Federal Employees Health Benefits program and private health plans participating in Medicare.

Marketplace Governance

Question: Many people feel that the current legal, regulatory, and administrative structures throttling the healthcare market are cumbersome and often an impediment to progress. What alternative governing mechanisms might be considered that would be more responsive? e.g., SEC-like model, healthcare court, community health planning, etc.

Public policy recommendations:

1. Uniformity is key. NQF rather than SEC like models will more successfully allow progress with standards.
2. HHS should support information sharing earlier in the regulatory or guidance design process, so those who regulate better understand how a particular regulation will play out in the local healthcare system.
3. The administration should encourage health plans and employers to broaden the participation of consumers and providers in governance issues by using the pharmacy and therapy committee model.

Implementation recommendations:

4. The administration should support, finance and endorse private efforts like those of Health Care Quality Forum to set standards for disclosing performance.
5. The administration should revamp federal anti-trust provisions

Medical Liability

Question: What actions could/should be taken by the President to address the medical liability problem and create a legal environment that fosters openness, disclosure and high quality patient care?

General comments: Our participants shared the conviction that our current system needs to deal with medical malpractice reform. They offered a variety of approaches for consideration. Alternative dispute resolution, limits on contingency fees, voluntary confidential reporting, caps on non economic damages, and creation of "medical courts" employing experts in medical issues and process were frequently cited. While important, the general feeling was crystallized by one participant, *"This issue is really a small piece of the pie, but it really divides the players!"*

Implementation recommendations:

1. The administration should explore greater use of alternative conflict resolution systems.
2. The administration should consider liability protections for healthcare workers providing care in the emergency room.
3. The administration should consider evidence-based safe harbors.
4. The administration should create health courts that compensate injured patients based on a schedule of benefits developed by independent medical experts, similar to the worker's compensation system.

5. The administration should establish a mandatory nationwide state-based error reporting system with whistle blower protections.
6. The administration should develop and publicize a 'rewards model' for arbitration and peer review.
7. The administration should consider adoption of the collateral source rule.
8. The administration should explore the idea of capping contingency fee arrangements.
9. The administration should consider caps on non-economic damages.
10. The administration should consider no fault settlement of suits through mandatory arbitration based upon clear standards, with exception of gross negligence.

National Study on Consumer Health Values

A Research Project Conducted for:

Wye River Group on Healthcare
Foundation for American Health Care Leadership

Field Work: December 16th through 19th, 2004

Project Directors:

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Introduction

The ***National Study on Consumer Health Values*** survey was conducted on behalf of Wye River Group by Harris Interactive. The survey was conducted with a nationally representative sample of 1,000 adults aged 18 and over in December 2004.

This survey is intended to contribute to the existing knowledge about consumer attitudes, values, and behaviors related to health care. In light of employers' and policymakers' growing interest in consumer-directed health care, consumers are likely to be facing more responsibility for the costs of and decisions about their health care. As consumer-directed health plans become more common, one of the possible challenges for employers and policymakers will be effectively motivating consumers to become more engaged in their health care, more committed to prevention and healthy lifestyles, and better informed in order to make choices based on cost and quality information. Given these priorities, it will become even more important to better understand how consumers view their role in health care decision-making, what aspects of health care they value most, and how they feel about making choices and possibly changing their lifestyles.

Summary of Key Findings

An effective approach to getting Americans more involved in health care decision-making will need to ensure that the health care system is easy to understand and navigate for consumers so that they may become more comfortable using information sources other than those upon which they have traditionally relied. Nearly two in three Americans feel that they would become more involved in decision-making if the health care system were easier to navigate. Reflecting a traditional reliance on physicians for making decisions about treatments or selecting specialists or hospitals on their behalf, over a third of consumers say they would still follow their doctor's advice even if it conflicted with reliable information from another knowledgeable source.

Given rising health care costs and data which shows few Americans are preparing financially for their future health care needs, it is significant that a large majority of adults say they would be willing to work an extra two or three years in order to ensure that they have enough money to pay for their health care in retirement. However, older adults – including those in their pre-retirement years – are less likely than younger adults to be willing to do so.

When it comes to perceptions about the quality of health care, the public holds mixed views. Americans appreciate that there are great differences between the quality of care provided by different hospitals and physicians for serious medical problems. However, they are not willing to pay more for access to better-quality hospitals or physicians. This may well be related to the fact that most Americans feel satisfied with their current physicians and would not change them even if cost (or other limitations) were not an issue. With this in mind, payers will need to use well-designed incentives to drive consumers to higher-quality providers.

Given that care for preventable chronic conditions accounts for a large proportion of all health care costs, employers, payers and policy-makers are becoming increasingly interested in motivating Americans to use prevention and lifestyle modification programs in order to decrease their health care costs in the long run.

Although Americans are by and large aware that a healthy lifestyle can improve and/or prevent many medical problems, they are generally unwilling to require people who are overweight or who do not exercise regularly to pay more for their coverage and care. This suggests that payers should rely on a system of incentives that emphasize rewards for healthy behaviors rather than punishment for unhealthy

habits. (One possible exception to this rule is smoking, as the public appears more willing to require smokers to pay more for their health insurance and health care.)

The public believes that the corporate profits—especially as related to pharmaceutical companies—and "waste in the system" are responsible for the rising costs of health care. Therefore, any actions designed to motivate the public to be more cost-efficient in their use of health care would need to overcome this perception.

Also, the public on balance is generally uncomfortable with the important ethical implications of putting a dollar value on living another year, which would presumably inform discussions about prioritizing resources for care in the final months of life.

SURVEY FINDINGS

Involvement in Decision-Making

Most Americans say they would be willing to become more involved in their health care decisions if the health care system were easier to navigate.

- Two in five Americans (40%) agree strongly and an additional quarter (24%) agree somewhat that, if the health care system were easier to navigate, they would be more involved in making health care decisions for themselves and their family. (Table 1)

A large minority of Americans would still follow their doctor's advice, even if it conflicted with reliable information from a knowledgeable source.

- More than a third (36%) agree somewhat or strongly that they would still follow their doctor's advice even if it conflicted with reliable information from a knowledgeable source. Less than half (46%) of Americans disagree somewhat or strongly that they would follow their doctor's advice in this situation. (Table 1)

Willingness to Work Extra Years to Cover Health Care Expenses in Retirement

A large majority of Americans say they would be willing work extra years to have enough money to pay for their health care in retirement.

- Three-quarters (74%) of Americans agree strongly or somewhat that they would be willing to work an extra two or three years in order to ensure they have enough money to pay for their health care in retirement. (Table 1)
- However, age plays a large role in whether or not Americans agree that they would be willing to work longer to pay for health care expenses. While nine in ten (88%) Americans age 18-24 agree strongly or somewhat that they would be willing to work longer, as the age of the respondent rises, the percentage of those willing to work additional years falls. For example, fewer than eight in ten (77%)of those age 35-44, seven in ten (72%) of those age 45-54, two-thirds (67%) of those age 55-64, and half (50%) of those 65 and older would be willing to work an extra two or three years to ensure they would have enough money to pay for their health care in retirement. (Table 1)

Perception of Quality and Value

A large majority of Americans believe that, when getting medical care for a serious medical problem, differences in quality between health care providers may mean the difference between life and death. However, majorities are unwilling to pay more for higher-quality care and think it is unfair to require patients to pay more for better care.

- More than three-quarters of Americans agree that where they receive medical care for a serious medical problem can influence whether they live or die, with 53% agreeing strongly and an additional 25% agreeing somewhat.. (Table 1)
- Fewer than one in five (16%)American adults would be willing to pay significantly higher premiums for a health insurance plan that provided coverage to go to hospitals and medical groups shown to provide better care. (Table 2)
- Two-thirds (64%) of Americans think it is unfair for patients to pay more to be treated by medical groups or hospitals that have been shown to provide better care. (Table 3)

Do Cost or Health Plan Limitations Keep Consumers With Current Providers?

If money were not an issue, only about two in five Americans would change where they receive their health care.

- Less than two in five (38%) Americans agree somewhat or strongly that, if they won the lottery, they would change where they get their health care. About half (51%) of Americans disagree somewhat or strongly that winning the lottery would prompt them to change where they get their health care. (Table 1)

Personal Responsibility for Health

Though Americans know that a healthy lifestyle can improve and/or prevent many medical problems, they are split on whether they agree that those who practice unhealthy lifestyles should pay more.

- Almost all (93%) Americans agree strongly or somewhat that, by making healthy lifestyle choices - such as not smoking, exercising frequently, and controlling their weight – they can prevent or improve many serious medical problems. (Table 1)
- A plurality of 46% say we should not require people with unhealthy lifestyles to pay higher premiums than people with healthy lifestyles, and a virtually identical plurality (47%) feel that we should not require people with unhealthy lifestyles to pay higher **deductibles or co-payments** for their medical care. (Table 4)
- However, when questions are asked about different types of health risks, attitudes vary depending on the type of risk involved. Majorities believe that smokers should pay more than non-smokers (58%) and that people who do not wear seat belts should pay more than people who do wear them (53%). On the other hand, only slightly more than a quarter of Americans believe that people who are overweight (27%) or people who do not exercise regularly (also 27%) should pay more. (Table 5)

Views of Rising Costs of Health Care

Americans attribute the rising costs of health care to a variety of factors, with high profits/drug companies and greed and waste in the system being cited most often.

- More than half of American adults feel that rising health care costs are due to high profits/drug companies (69%), greed and waste in the system (62%), the aging of the population (55%), and malpractice lawsuits (54%.) By contrast, fewer Americans attribute rising costs to the use of expensive medical technologies (46%) or the fact that consumers have little incentive to seek lower cost care (39%.) (Table 6)

What is a Life Worth?

On balance, Americans are not willing to put a dollar value on living another year.

- Only three in ten (31%) Americans agree strongly or somewhat that society should put a dollar value on living another year. (Table 1)
- About half (48%) of Americans disagree strongly or somewhat with society putting a dollar value on living another year to help decide how much money to spend on prolonging lives. (Table 1)
- The remaining 21 percent of American adults are undecided on this issue. (Table 1)

Methodology

The Harris Poll® was conducted by telephone within the United States between December 16 and 19, 2004 among a nationwide cross section of 1,023 adults (aged 18 and over). The Harris sample makes use of a random-digit-dial (RDD) selection procedure that assures representation of persons in households that are "listed" in telephone directories, as well as persons in households that are "unlisted" in telephone directories. Figures for age, sex, race, education, region and household income were weighted where necessary to bring them into line with their actual proportions in the population.

In theory, with probability samples of this size, one could say with 95 percent certainty that the results have a sampling error of plus or minus 3 percentage points of what they would be if the entire U.S. adult population had been polled with complete accuracy. Unfortunately, there are several other possible sources of error in all polls or surveys that are probably more serious than theoretical calculations of sampling error. They include refusals to be interviewed (nonresponse), question wording and question order, interviewer bias, weighting by demographic control data and screening (e.g., for likely voters). It is impossible to quantify the errors that may result from these factors.

TABLE 1
AGREEMENT WITH STATEMENTS ABOUT HEALTH VALUES
"How much do you agree or disagree with the following statements?"

Base: All Adults

		Agree strongly	Agree somewhat	Neither agree nor disagree	Disagree somewhat	Disagree strongly	Don't Know	Decline to answer
If the healthcare system were easier to navigate, I would be more involved in making healthcare decisions for myself and my family	%	40	24	9	10	10	6	1
If I had reliable information from a knowledgeable source - for example, the Mayo Clinic or Johns Hopkins - that conflicted with my doctor's opinion, I would still follow my doctor's advice	%	20	16	11	22	24	6	1
I would be willing to work an extra two or three years in order to ensure I have enough money to pay for my healthcare in retirement	%	52	22	5	5	9	6	1
Where I go to receive medical care for a serious medical problem can influence if I live or die	%	53	25	5	6	4	6	1
If I won the lottery tomorrow, I would change where my family and I get our healthcare	%	28	10	8	18	33	3	1
By making healthy lifestyle choices – such as not smoking, exercising frequently and controlling my weight - I can prevent or improve many serious medical problems	%	81	12	2	2	1	2	1
Society should put a dollar value on living another year to help decide how much to spend on prolonging lives	%	15	16	11	18	30	9	1

Source: Harris Poll December 16-19 2004

TABLE 2
PAYING FOR QUALITY
Would you be willing to pay significantly higher premium for a health insurance plan which covered you to go to hospitals and medical groups shown to provide superior care?

Base: All Adults

	% **saying they would be...**
Willing	16
Not willing	60
Not sure	23

Source: Strategic Health Perspectives- 2004- Survey of the Public

TABLE 3
PAYING FOR QUALITY
Do you think it would be fair for patients to pay more to be treated by medical groups or hospitals which have been shown to provide better care?

Base: All Adults

	% **saying it would be...**
Fair	18
Not fair	64
Not sure	18

Source: Strategic Health Perspectives- 2004- Survey of the Public

TABLE 4
FAIR OR UNFAIR FOR PEOPLE WITH UNHEALTHY LIFESTYLES TO PAY MORE FOR INSURANCE OR CARE?

"People who have healthy lifestyles, don't smoke, exercise frequently and control their weight tend to incur fewer health care costs than people with unhealthy lifestyles. Do you think it would be fair or unfair . . . ?"

Base: All Adults

	All Adults	**Sex**		**Education**			
		Men	**Women**	**High School or Less**	**Some College**	**College Grad**	**Post Grad**
	%	%	%	%	%	%	%
To ask people with unhealthy lifestyles to pay higher health insurance premiums than people with health lifestyles							
Fair	37	48	27	27	37	49	57
Unfair	46	38	53	56	43	35	29
Not sure	17	14	20	17	20	16	14
To ask people with unhealthy lifestyles to pay higher deductibles or co-payments for their medical care than people with unhealthy lifestyles							
Fair	36	45	27	28	35	48	52
Unfair	47	41	53	55	45	38	34
Not sure	17	14	20	17	20	14	14

Source: Wall Street Journal/Harris Interactive Healthcare Poll conducted online between October 30th and November 3rd 2003, with a nation wide cross-section of 2,231 adults 18 an over.

TABLE 5
FAVOR/OPPOSE DIFFERENT PREMIUM OR COST-SHARING FOR PEOPLE WITH DIFFERENT LIFE STYLES
"Would you favor or oppose different levels of health insurance premiums, co-payments or deductibles for . . .?"

Base: All Adults

	All Adults	Sex		Education			
		Men	Women	High School or Less	Some College	College Grad	Post Grad
	%	%	%	%	%	%	%
Smokers vs. non-smokers							
Favor	58	63	53	44	60	72	82
Oppose	31	29	32	41	28	20	13
Not sure	12	8	15	14	12	9	6
People who are overweight vs. people who are within their recommended weight							
Favor	27	35	20	24	23	35	39
Oppose	52	47	57	56	55	44	40
Not sure	21	18	23	20	22	20	21
People who do not wear seat belts vs. people who do wear seat belts							
Favor	53	56	50	44	56	59	69
Oppose	33	32	34	40	30	30	19
Not sure	14	12	16	16	14	11	12
People who exercise regularly vs. people who do not exercise regularly							
Favor	27	33	22	22	24	36	42
Oppose	52	48	56	58	53	45	35
Not sure	21	19	22	19	23	19	23

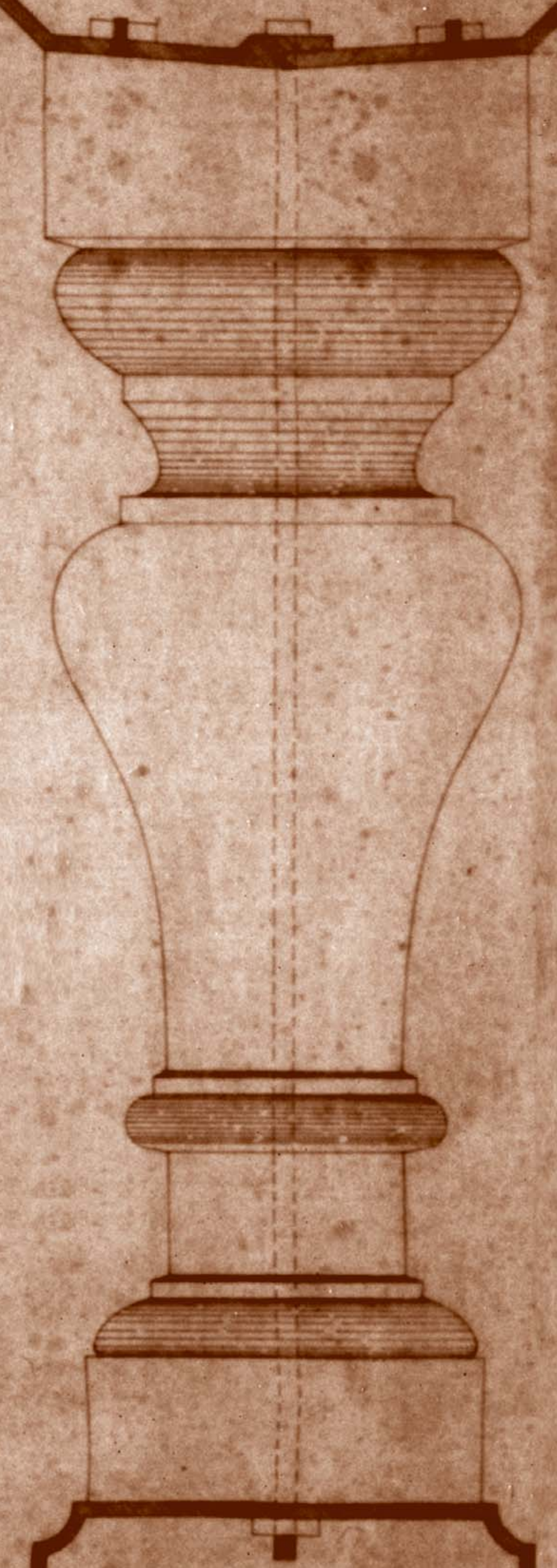
Source: Wall Street Journal/Harris Interactive Healthcare Poll conducted online between October 30th and November 3rd 2003, with a nation wide cross-section of 2,231 adults 18 an over.

TABLE 6
RISING HEALTH CARE COSTS
What Is Responsible for Rising Health Care Costs?

Base: All Adults

	% saying very important factor
High profits/Drug companies	69
Greed and waste in system	62
Aging of the population	55
Malpractice suits	54
Use of expensive medical technologies	46
Consumers have little incentive to seek lower cost care	39

Source: Harvard School of Public Health/Kaiser Family Foundation, October 2004.



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